	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING O O O O O O O O O O O O O			(X3) DATE SURVEY COMPLETED 07/18/2014	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE	07710	2011
INDEPE	NDENT LIVING CLU	JB		INDIAN	APOLIS, IN 46224		
(X4) ID PREFIX TAG R000000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	S NATE	(X5) COMPLETION DATE
	Complaints IN00 IN00152686. Complaint IN00 State deficiencie allegations are circle allegations are circle allegations are circle allegations are circle at R0298 and R041 Complaint IN00 State deficiency is cited at R0149 Survey Dates: July 17 & 18, 20 Facility number: Provider number AIM number: N Survey Team: Mary Jane G. Fist Census bed type: Residential: 44 Total: 44 Census payor type Other: 44 Total: 44 Sample: 7	152030 - Substantiated. s related to the ted at R0241, R0247, 2, . 152686 Substantiated. related to the allegation . 14 001132 : NA A		0000	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Page 1 of 26 State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2014 FORM APPROVED OMB NO. 0938-0391

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED 07/18/2014
	ROVIDER OR SUPPLIER	lB	6038 V	ADDRESS, CITY, STATE, ZIP CODE V 25TH ST NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	These State findi accordance with Quality review of Brenda Marshall	ngs are cited in 410 IAC 16.2-5. completed 7/21/14 by			
R000149	(f) The facility shal program in operation IAC 7-24. Based on observation interview, the facility environment of	ety Standards - Deficiency I have a pest control on in compliance with 410 ation, record review and cility failed to ensure an atrol program and that comment was free from ts. This deficient all areas of the facility, a, dining room, resident coms, the nurses' station, work area and I common areas.	R000149	The corrective action accomplished was to install bug lights that the surveyor to the pest control agent ab and to get the hot spot foan also talked to him about the facility will id other residents having the potential to be at by watching resident rooms do not have gnats to ensure do not get them the measure put into place were to instal bug lights and have the pest control bring the hot spot for kill the gnat eggs the corrections will be monitored by maintenance and houseked staff by touring res rooms of and also the pest control coon site two times a week monitoring the situation. addendum: the facility does will continue to monitor resi rooms on a daily basis to en	talked out out on she e e s ffected that e they cres I the et am to ctive of the eping aily omp is

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 2 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
			A. BUII B. WIN			07/18/	2014
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			' 25TH ST		
	NDENT LIVING CL	UB	INDIANAPOLIS, IN 46224				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and landing on furniture, bedding,				compliance. this will continue		
	inanimate object	ts and bathroom fixtures.			long as a resident resides in t		
	The Director of	Operations indicated			rooms. the housekeeping staff the main staff doing the tours		
		plem with the gnats.			they do the routine cleaning	as	
	distre was a proc	yadaa waxaa gaadaa			services. the maint staff over		
	A review of the	contracted Pest Control			sees should a problem arise. t	the	
					housekeeping staff reports in	to	
		es indicated the facility			the office mgr and maint supe		
	_	l pest control treatment			they see a problem with gnats		
	_	anuary 2014 thru June			the pest control company is or		
	2014. The invol	ices did not indicate any			site once a week monitoring the		
	special treatment for the gnats.				gnats as well. the staff tours we the pest control company and		
		_			keeps an ongoing progress lis		
	During an interv	view on 07-17-14 at 10:15			this is kept with the office		
	_	taff member employee #5			mgr. the pest control also		
	1				ensures the lights are working		
	-	seen the gnats, but we			properly as well.		
		nes or mice. They're					
	everywhere. Th	ey're bad this time of the					
	year. "						
	During an interv	view on 07-17-14 at 10:30					
		teeper employee #6					
	-						
		ats had gotten worse					
	1	ne flew in her eye the					
		t was "hard to get it out of					
	my eye." The h	ousekeeper indicated she					
	had put vinegar	and baking soda down					
	the resident bath	nroom drains, but that					
		a short time. Part of the					
		esidents have wet towels,					
	_						
washcloths, partially filled coffee cups							
and water glasses in their rooms which							
	just make the make	atter worse."					
		9:15 a.m. the					

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 3 of 26

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILL B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 07/18/	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6038 W 25TH ST INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE	
	control company representative in the problem of the bad. "I used strict They [in regard thigh rate. They jugoing to have to the problem in the treatment of the levinegar only take that doesn't solve to get a special fed because that processing the because that processing to the problem in the levinegar only take the doesn't solve to get a special fed because that processing the problem in the levinegar only take the problem in the levinegar only take the problem in the levinegar only take the levinegar o	was interviewed. The dicated he was unaware the gnats had gotten so ps to try and trap them. The other gnats breed at a fast breed so fast. I'm find the main source of the building. The baking soda and the so off the top layer, but the problem. I'll have the problem. I'll have the problem at the enzymes sying their eggs. "						
R000241	the provision of rest be as ordered by the and shall be super on the premises of (1) Medication shall licensed nursing predication aides. Based on record interview, the fact prophylactic mediagnosis of possibility administered according to the properties of the pr		R000	241	the corrective action accomplished is to ensure prophylactic meds are administered correctly. the fac will id other residents having th potential to be affected by a m audit of any other resident receiving a prophylactic med.	ne ed	07/30/2014	

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 4 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
			B. WIN			07/18/	2014
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			/ 25TH ST		
INDEPE	NDENT LIVING CLU	JB.			APOLIS, IN 46224		
						1	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD BE ACTION.		PROVIDER'S PLAN OF CORRECTION		(X5)
TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	 	,	+	TAG	measures put into place will be		DATE
	medication administration in a sample of				the nursing staff will be in	5	
	7 residents (Resi	idents B, D, and E).			compliance with the regs and	of	
					their own professional practice		
	Findings includ	e:			med administration. the rn		
					provided medication education	n to	
	1. The record for	r Resident "B" was			the nursing staff re this finding		
		17-14 at 10:35 a.m.			the rn moved the locale of said	t	
	Diagnoses included, but were not limited				meds in question to the top		
to, positive PPD (Purified Protein					drawer of med cart. a sign in sheet is made of med received	۱ if	
	Derivative - a method use to diagnose				a duplicate bottle is sent to the		
1					facility from the pharmacy, it w		
tuberculosis infection), history of cocaine				be immediately returned and r			
	and alcohol abuse, and chronic paranoid				kept as it was in this case. the	e rn	
	schizophrenia.	These diagnoses			will monitor her staff as to the		
	remained curren	t at the time of the record			meds prescribed. the rn will		
	review. The resi	ident was admitted to the			accept all dr orders herself on		
	facility on 12-31	-13			admin record that was created the rn the nsg staff was	Бу	
					inserviced on this policy july		
	Prior to admission	on to the facility the			30,2014 addendum: the facilit	:V	
		•			will not accept any meds that a		
		nest x-ray. During an			not from the ordered prescribe		
		18-14 at 8:15 a.m., a			the DON does random med pa		
		on County Health Nurse			observation of the nsg staff at		
	indicated the res	ident was being treated			of our med times to ensure the nsg staff is performing their jol		
	with prophylacti	c medications for			duties correctly. by checking a		
	tuberculosis at th	ne time of admission. " I			random times and	`	
	gave the facility	a one month supply of			with different staff		
		when he got there.			members, the DON ensures to		
		ck to the facility I			see all of the staff, therefore		
		ere still capsules left in			keeping in compliance. the	:	
		le. I told the Director of			monitoring of the med records done 4x a month. the pharmac		
	_				sends the med sheet, the DON		
	Nurses and spok	e with the doctor."			audits med sheet, makes all	•	
	The	mining and an electrical			changes, the medical director		
	The current physician order, dated				confirms the DON audit by		
	*	icted the nurse to			signing off on the med sheet,		
	administer Rifan	npin (a medication in the			then the pharmacy consultant		

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 5 of 26

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
			B. WIN			07/18/	2014
NAME OF I	DROVADED OD GLIDDLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C	6038 W 25TH ST				
INDEPE	NDENT LIVING CLU	JB	INDIANAPOLIS, IN 46224				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	treatment of latent tuberculosis), 300 mg				checks the med sheet upon return to the pharmacy for		
		apsules orally once a day			monthly fill. the monthly fill cor	nes	
	time four month	s. "			in atc packs from the pharmac		
					should there be a med change		
	During an observ	vation on 07-17-14 at			the DON will update med book	(
	11:00 a.m., with	the Registered Nurse # 3			immediately upon notification from dr. as well as make chan	200	
	and Qualified M	edication Aide #8 in			in atc pack and notify prescribe		
	attendance the m	nedication was reviewed,			of said changes. charting is do		
	and the capsules were counted. The resident had three bottles of the medication. Bottle #1 was dated 05-09-14 and				also in resident file. the DON v		
					continue to ensure complianc	е	
					daily during her continued job duties, the medical director is	aleo	
					in contact with DON should an		
					problems arise.	,	
	indicated 60 cap	sules were delivered.					
	_	Nurse indicated 40					
	capsules remaine						
	Bottle #2 was da	nted 06-06-14 and					
	indicated 60 cap	sules were delivered.					
	The Registered 1	Nurse indicated 44					
	capsules remaine	ed in the bottle.					
	Bottle #3 was da	ated 07-04-14 and					
	indicated 60 cap	sules were delivered.					
	The Registered 1	Nurse indicated 41					
	capsules remaine	ed in the bottle.					
	At the time of th	is observation, the					
	07-04-14 bottle	#3, 26 doses should have					
	been administere	ed to the resident and not					
	the 19 doses as i	ndicated by the nurse.					
	Further review of the resident record						
		ntract for Assisted					
	Comamed a Col	maci idi Assisted					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING B. WING	00	— COMI	E SURVEY PLETED B/2014	
	PROVIDER OR SUPPLIER		6038 W	ADDRESS, CITY, STATE, ZIP C ' 25TH ST APOLIS, IN 46224	CODE	
(X4) ID PREFIX TAG	Living" dated 1: "Medication modinclude monitoring prescribed times the resident. During this obsess Medication Aided did not refuse his Qualified Medication Aided did not refuse his Qualified Medication finished these body. The record for reviewed on 07-Diagnoses included, schizo-effect dementia, tobaccastroke. These discurrent at the time. A review of a result of the control of the contro	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) 2-31-13, which indicated, nitoring service shall ng correct medication at ," which was signed by rvation the Qualified e indicated the resident s medications. The ation Aide further stated, why they keep bringing us a when we haven't		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE J DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 7 of 26

i î		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
			B. WIN	G		07/18/	2014
NAME OF F	ROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP CODE		
					25TH ST		
INDEPE	NDENT LIVING CLU	JB		INDIAN	APOLIS, IN 46224		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
		er dated 02-28-14					
instructed the nursing staff to administer							
	•	g capsule 1 orally once a					
	day.						
	The record lacked any further assessment.						
	A nurses note da	nted 04-08-14 at 10:00					
		"Res. [resident] spitting					
up blood in a bag. This writer caught							
him doing this around 9:00 a.m. Res. is							
	being sent to [name of local area						
		nergency Room] with					
		The resident returned to					
	the facility with	2 prescriptions which					
	included Prednis	sone (a steroid) and					
	Doxycycline (an	antibiotic).					
	No further asses	sment was conducted for					
	this resident.						
	The nurses notes	s further indicated the					
	resident was to b	be seen by an Infectious					
	Disease physici	an on 06-10-14. The					
	clinical record la	acked documentation of					
	the purpose or re	esults from this physician					
	visit.						
	_	vation on 07-17-14 at					
	•	the Registered Nurse # 3					
	•	edication Aide #8 in					
		nedication Rifampin,					
	were observed. The resident had three						
	bottles of the me	edication.					

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 8 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE COMP 07/18		
	PROVIDER OR SUPPLIER		6038 V	ADDRESS, CITY, STATE, ZIP COI V 25TH ST NAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	indicated 30 caps	ted 06-15-14 and sules were delivered. Vurse indicated 26 ed.				
	indicated 30 caps	ted 07-13-14 and sules were delivered. Nurse indicated 30 ed.				
	contained a "Co Living," dated 1 "Medication mod include monitori	f the resident record ntract for Assisted 1-2009 which indicated, nitoring service shall ng correct medication at ," and was signed by the				
	Medication Aide	rvation the Qualified #8 indicated the refuse medications.				
	reviewed on 07-Diagnoses included to, emphysema, PPD and a historic diagnoses remains the record review admitted to the f	r Resident "E" was 17-14 at 12:00 p.m. ded, but were not limited hypertension, positive by of TB. These ned current at the time of w. The resident was acility on 10-15-2010 array prior to admission.				
		ded the resident's most y dated 02-27-14 which				

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 9 of 26

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/18/2014
	PROVIDER OR SUPPLIER NDENT LIVING CLUB	6038 W	ADDRESS, CITY, STATE, ZIP CODE 25TH ST APOLIS, IN 46224	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
	indicated, "Patient Care Advisory on [name of resident]. Please note that a chest x-ray on the resident noted above which was reported with a positive result. Consider this a courtesy reminder that a reassessment of the resident may be necessary at this time." The examination results indicated, "Active TB cannot be excluded." A physician order dated 02-28-14 instructed the nursing staff to administer Rifampin 300 mg capsule 1 orally once a day - " no stop date." The record lacked any further assessment. During an observation on 07-17-14 at 11:00 a.m., with the Registered Nurse # 3 and Qualified Medication Aide #8 in attendance the medications were observed. The resident had three bottles of the medication. Bottle #1 was dated 05-23-14 and indicated 30 capsules were delivered. The Registered Nurse indicated 21 capsules remained. Bottle #2 was dated 06-20-14 and indicated 30 capsules were delivered. The Registered Nurse indicated 14 capsules remained.			

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 10 of 26

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			A. BUILDING B. WING		07/18/2014
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	S.		/ 25TH ST	
	IDENT LIVING CLU		INDIAN	IAPOLIS, IN 46224	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		f the resident record			
		ntract for Assisted			
	Living," dated 10-15-10 which indicated, "Medication monitoring service shall				
	include monitori	ng correct medication at			
	prescribed times	," which was signed by			
	the resident.				
	During this obse	rvation the Qualified			
	Medication Aide #8 indicated the resident did not refuse his medications.				
			1		
	TEL: CL .				
		lates to Complaint	1		
	IN00152030.				
R000247	410 IAC 16.2-5-4(a)/7)	1		
11000247	Health Services -	* * *	1		
		edication administration			
		he resident 's record. The	1		
	physician shall be	notified of any error in	1		
		istration when there are	1		
		ntial detrimental effects to	1		
	the resident.	maniana alaamadisa sa 4	D000247	the corrective action is to notif	07/20/2014
		review, observation, and	R000247	the corrective action is to notife the physician of all future med	
		cility failed to ensure the	1	errors as well as document the	
		otified of medication		in the residents files the facilit	
	errors and failed	to ensure documentation		will id other residents by doing	-
	of the errors in re	esidents' records for 3 of		count of all vial meds the	
	3 residents revie	wed for medication		measures put into place are to	
	errors in a sample of 7 (Residents B, D			a count of all vial meds, meds	
	and E).	2, 2		this nature, not in atc packs, w	
	ши <i>ப</i> ј.		1	remain in the top drawer of me cart with a sign in sheet, these	
				Sart with a sign in sheet. these	´

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 11 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	ILTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED
			B. WINC	3 <u> </u>		07/18/2014
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					25TH ST	
INDEPE	NDENT LIVING CLU	JB		INDIAN	APOLIS, IN 46224	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Findings include	:			sheets will be signed in and or	
				for all meds that come before new atc packs arrive the facili	 	
	1. The record fo	r Resident "B" was			met with the medical director t	•
	reviewed on 07-	17-14 at 10:35 a.m.			whom these residents in ques	tion
	Diagnoses includ	led, but were not limited			have been repeatedly reported	
	to, positive PPD	(Purified Protein			said director. the med director	
	. •	ethod use to diagnose			confident the proof of meds we administered, the med dir state	
		ction), history of cocaine			that if they were not there wou	
		e, and chronic paranoid			have been evidence of	
	schizophrenia. T	_			granulomatous tissue. there w	as
	•	t at the time of the record			no indication on f/u cxr. the	
	review. The resident was admitted to the				meeting with med director and	
					nursing education was july 30, 2014 addendum: the	
	facility on 12-31	-13.			facility adapted a form from	
	D: . 1 : :				briggs for med errors.it	
		on to the facility the			includes space for resident na	· · · · · · · · · · · · · · · · · · ·
		est x-ray. During an			date, times, med, dosage, wh	
		18-14 at 8:15 a.m., a			made error, place for physicia	
		on County Health Nurse			notes, descriptions, outcomes and actions taken. it is availal	
		ident was being treated			for use by the nursing staff. th	
	with prophylaction	c medications for			DON will report all med errors	
	tuberculosis at th	ne time of admission. "I			the physician. med compliance	e is
	gave the facility	a one month supply of			observed daily by all nsg	
	the medications	when he got there.			staff during all med passes. if any med errors are noticed, th	
	When I went bac	ek to the facility I noticed			don would be immediately	
	there were still c	apsules left in the			notified. she in turn will	
		told the Director of			immediately notify the	
	_	e with the doctor."			physician. the new form adapt	
					would be used in this instance and sent to med director,	
	The current nhvs	sician order dated			physician and filed in resident	
	The current physician order, dated 04-11-14, instructed the nurse to administer Rifampin (a medication in the				file. this will be continued on a	
					daily basis as long as the facil	ity
treatment of latent tuberculosis), 300 mg (millegrams) 2 capsules orally once a day				exists.		
	`					
	times four month	is. "				

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 12 of 26

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD B. WING		00	(X3) DATE : COMPL 07/18 /	ETED
	PROVIDER OR SUPPLIER			6038 W	DDRESS, CITY, STATE, ZIP CODE 25TH ST APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	11:00 a.m., with and Qualified M attendance the m and the capsules resident had three medication. Bottle #1 was daindicated 60 cap The Registered M capsules remained a lindicated 60 cap The Registered M capsules remained a lindicated 60 cap The Registered M capsules remained a lindicated 60 cap The Registered M capsules remained a lindicated 60 cap The Registered M capsules remained a lindicated 60 cap The Registered M capsules remained a lindicated 60 cap The Registered M capsules remained a lindicated 60 cap The Registered M capsules remained a lindicated 60 cap The Registered M capsules remained a lindicated 60 cap The Registered M capsules remained a lindicated 60 cap The Registered M capsules remained been administered the 19 doses as in lindicated Medication Aided did not refuse his Qualified Medication Med	ted 05-09-14 and sules were delivered. Nurse indicated 40 ed in the bottle. ted 06-06-14 and sules were delivered. Nurse indicated 44 ed in the bottle. ted 07-04-14 and sules were delivered. Nurse indicated 41					

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 13 of 26

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
			B. WIN			07/18/2014
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				25TH ST	
	NDENT LIVING CLU	JB			APOLIS, IN 46224	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)	DATE
		when we haven't				
	finished these bo	ottles yet."				
		ed documentation the				
	physician was no	otified of the medication				
	error.					
		r Resident "D" was				
		17-14 at 11:30 a.m.				
	-	ded, but were not limited				
	to, schizo-effective disorder, vascular					
	dementia, tobacc	o use and frontal lobe				
	stroke. These di	agnoses remained				
	current at the tim	ne of the record review.				
	A review of a red	cent chest x-ray dated				
	02-27-14 indicat	ed, "Patient Care				
	Advisory on [nai	me of resident]. Please				
	•	x-ray on the resident				
		ch was reported with a				
		Consider this a courtesy				
		eassessment of the				
		necessary at this time."				
	I	results indicated -				
	"Active TB cann					
	Active 1D cann	iot oc excluded.				
	A nhysician orde	er, dated 02-28-14				
		rsing staff to administer				
		•				
		g capsule -1 orally - once				
	a day.					
	During an observ	vation on 07-17-14 at				
	_	the Registered Nurse # 3				
	· ·	edication Aide #8 in				
	<		1			

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 14 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
			B. WIN			07/18/	2014
		<u> </u>	B. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			25TH ST		
INDEPE	NDENT LIVING CLU	JB	INDIANAPOLIS, IN 46224				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
		nedication Rifampin,					
	were observed.	The resident had three					
	bottles of the medication.						
	Bottle #1 was da	ated 06-15-14 and					
	indicated 30 cap	sules were delivered.					
	_	Nurse indicated 26					
	capsules remain						
	T						
	Bottle #2 was dated 07-13-14 and						
		sules were delivered.					
	_						
	The Registered Nurse indicated 30						
	capsules remain	eu.					
	F	£41 i i i					
		of the resident record					
		ontract for Assisted					
	_	11-2009 which indicated,					
		nitoring service shall					
	include monitori	ing correct medication at					
	prescribed times	," and was signed by the					
	resident.						
	The resident's re	cord lacked					
	documentation t	he physician had been					
	notified of the m	1					
	3. The record for	or Resident "E" was					
		17-14 at 12:00 p.m.					
		ded, but were not limited					
	~	hypertension, positive					
	1 1 1	7.1					
	PPD and a histor						
	1 -	ned current at the time of					
		w. The resident was					
	admitted to the f	facility on 10-15-2010					

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 15 of 26

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING			COMPLETED 07/18/2014		
	PROVIDER OR SUPPLIER			6038 W	ddress, city, state, zip code 25TH ST APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) A-ray prior to admission.		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	The record includer recent chest x-ray indicated, "Patien [name of resident chest x-ray on the which was reported to consider this a consider this a consider this a consider this a consider this and reassessment of the necessary at this results indicated, excluded." A physician order instructed the nur. Rifampin 300 mg day - "no stop	ded the resident's most y dated 02-27-14 which ent Care Advisory on t]. Please note that a e resident noted above ted with a positive result. ourtesy reminder that a che resident may be time." The examination "Active TB cannot be er dated 02-28-14 rsing staff to administer g capsule 1 orally once a te." Vation on 07-17-14 at the Registered Nurse # 3 edication Aide #8 in edications were esident had three bottles in. Ited 05-23-14 and sules were delivered. Jurse indicated 21 ed.					

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 16 of 26

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING			COMPLETED 07/18/2014			
	PROVIDER OR SUPPLIER	IB	STREET ADDRESS, CITY, STATE, ZIP CODE 6038 W 25TH ST INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
R000298	contained a "Contained a "Contained a "Contained a "Contained," dated 1 "Medication mori include monitoring prescribed times, the resident. The resident's reduction of the motified of the m	f the resident record atract for Assisted 0-15-10 which indicated, nitoring service shall ag correct medication at " which was signed by cord lacked ae physician had been edication error. ates to Complaint c)(2) ervices - Deficiency narmacist shall be er contract, and shall: for the duties as specified g handling and storage cility; tation on methods and ering, storing, disposing of drugs as	R00	0298	the corrective action is to notify the consultant of the deficiency the facility will discuss with the	y.	08/08/2014	

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 17 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DINC	00	COMPLE	ETED
			B. WING			07/18/2	2014
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			25TH ST		
INDEPE	NDENT LIVING CLU	JB			APOLIS, IN 46224		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	resident's medica	ation regime, in that			consultant so she can ensure		
	when residents h	nad specific physician			other residents have potential		
	orders for proph	ylactic medications in the			to be affected by her own mea of practice the measure put in		
		erculosis, the pharmacist			place will be that of the pharm		
		le the medications and			consultant as this facility does	not	
		strative staff of any			employ her. it is not this facilitie		
		-			deficient practice. it is that of the	ne	
		e residents medication			pharmacy meeting with the		
	regime for 3 of				consultant again the week of	.h.a	
	-	ssible tuberculosis in a			august 4th, 2014 addendum: facility met with the rx consulta		
	-	esidents "B", "D" and			and relayed the info. in question		
	"E").				the consultant then had a mee		
					with her supervisors and let the	~	
	Findings include	e:			know info. as well as the med	cart	
					techs that come to all of their		
	1 The record for	r Resident "B" was			contracted facilities. they used		
		17-14 at 10:35 a.m.			info given to them as a teaching		
		ded, but were not limited			tool for their staff to ensure the are meeting compliance when	y	
	_				they visit the facility. addendu	ım:	
		(Purified Protein			the facility has been given the		
		ethod use to diagnose			grievance policy from the		
		ection), history of cocaine			pharmacy and instructions if it	is	
	and alcohol abus	se, and chronic paranoid			deemed necessary to use. the		
	schizophrenia.	These diagnoses			facility will investigate any		
	remained curren	t at the time of the record			discrepancy and report to the pharmacy, the facility has also		
	review. The resi	ident was admitted to the			been given the pharmacy police		
	facility on 12-31	-13.			and procedures for dispensing		
					errors. the facility is to follow		
	Prior to admission	on to the facility the			pharmacy protocol for		
		nest x-ray. During an			appropriateness should a		
		ž e			problem arise, the consultant	for	
		18-14 at 8:15 a.m., a			pharmacist will be responsible general supervision of	101	
		on County Health Nurse			accountability dispensed meds	_{s. a}	
		ident was being treated			report of said findings will be	-	
		c medications for			provided to the don and director	or	
	tuberculosis at th	ne time of admission. " I			to ensure communication on the		
	gave the facility	a one month supply of			status of pharmaceutical service	ce	

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 18 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		07/18/2014
N	DOLUBED OF SUPER-	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			/ 25TH ST	
	NDENT LIVING CLU		INDIAN	IAPOLIS, IN 46224	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	,	DATE
		when he got there.		within the facility. the consulta said she was going to have a	nt
		ck to the facility I		quality assurance meet with h	er
		re still capsules left in		staff to help identify these	
	the original bottl	e. I told the Director of		excessive quantities througho	ut
	Nurses and spok	e with the doctor."		all of the facilities they contract	l l
				with, they hope to enhance the	9
	The current phys	sician order, dated		effectiveness of their services through this process.	
	04-11-14, instru			unough this process.	
	· · · · · · · · · · · · · · · · · · ·	npin (a medication in the			
		nt tuberculosis), 300 mg			
		apsules orally once a day			
	time four months	_			
	time rour monus	5.			
	During an observ	vation on 07-17-14 at			
		the Registered Nurse # 3			
		_			
	-	edication Aide #8 in			
		nedication was reviewed,			
	_	were counted. The			
	resident had thre	e bottles of the			
	medication.				
	Dottle #1 1-	tod 05 00 14 and			
		ated 05-09-14 and			
	_	sules were delivered.			
		Nurse indicated 40			
	capsules remaine	ed in the bottle.			
	Bottle #2 was da	ted 06-06-14 and			
		sules were delivered.			
	_	Nurse indicated 44			
	capsules remaine				
	capsules remaine	ou in the bottle.			
	Bottle #3 was da	ted 07-04-14 and			
		sules were delivered.			
	-	Nurse indicated 41			
	The registered i	Tarso marcutoa Tr			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	LDING	00	COMPL	ETED
			B. WIN			07/18/	2014
		1	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			25TH ST		
INDEPE	NDENT LIVING CL	JB			APOLIS, IN 46224		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	capsules remain	ed in the bottle.					
	At the time of th	is observation, of the					
	07-04-14 bottle	#3, 26 doses should have					
		ed to the resident and not					
		indicated by the nurse.					
	uic 17 doses as 1	marcacca by the nurse.					
	E	of the resident record					
		ntract for Assisted					
	_	2-31-13, which indicated,					
	"Medication monitoring service shall						
	include monitor	ing correct medication at					
	prescribed times	s," which was signed by					
	the resident.						
	During this obse	ervation the Qualified					
		e indicated the resident					
		s medications. The					
		eation Aide further stated,					
	-	why they keep bringing us					
		, , , , ,					
		n when we haven't					
	finished these bo	ottles yet."					
		June 2014 re-write of					
	physician orders	s indicated the					
	medications wer	re reviewed by the					
	pharmacist.						
	2. The record for	or Resident "D" was					
	reviewed on 07-	17-14 at 11:30 a.m.					
		ded, but were not limited					
	~	ive disorder, vascular					
		co use and frontal lobe					
	•						
	stroke. These di	iagnoses remained					

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 20 of 26

	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	` <i>′</i>	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		LETED
			B. WING		07/18	3/2014
			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹	6038	W 25TH ST		
INDEPE	NDENT LIVING CL	JB		ANAPOLIS, IN 46224		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	current at the tin	ne of the record review.				
	A review of a re	cent chest x-ray dated				
		ted, "Patient Care				
		me of resident]. Please				
		-				
		x-ray on the resident				
		ich was reported with a				
	1 ^	Consider this a courtesy				
	reminder that a i	reassessment of the				
	resident may be	necessary at this time."				
The examination results indicated -						
"Active TB (tuberculosis) cannot be						
	excluded."					
	excluded.					
	A physician ord	er dated 02-28-14				
	1	rsing staff to administer				
		g capsule 1 orally once a				
	_	g capsure 1 orany once a				
	day.					
	During an obser	vation on 07-17-14 at				
	11:00 a.m., with	the Registered Nurse # 3				
		ledication Aide #8 in				
	`	nedication Rifampin,				
		•				
		The resident had three				
	bottles of the me	edication.				
	Bottle #1 was da	ated 06-15-14 and				
	indicated 30 can	sules were delivered.				
	_	Nurse indicated 26				
	_					1
	capsules remain	cu.				
	Bottle #2 was da	ated 07-13-14 and				
	indicated 30 cap	sules were delivered.				1
	_	Nurse indicated 30				
]		l			1

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 21 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP	ESURVEY LETED 3/2014	
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CO 25TH ST APOLIS, IN 46224	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ed.	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Further review of contained a "Co Living," dated 1 "Medication morinclude monitoring prescribed times resident. A review of the physician orders medications were pharmacist. 3. The record for reviewed on 07-Diagnoses included, emphysema, PPD and a historic diagnoses remains the record reviewed admitted to the fand had a chest of the record included.	f the resident record ntract for Assisted 1-2009 which indicated, nitoring service shall ng correct medication at ," and was signed by the June 2014 re-write of indicated the e reviewed by the r Resident "E" was 17-14 at 12:00 p.m. ded, but were not limited hypertension, positive				
	[name of residen chest x-ray on th which was repor Consider this a c reassessment of	nt Care Advisory on at]. Please note that a e resident noted above ted with a positive result. ourtesy reminder that a the resident may be time." The examination				

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 22 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COM	E SURVEY PLETED 8/2014			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 6038 W 25TH ST INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
	results indicated excluded."	, "Active TB cannot be						
	instructed the nu	er dated 02-28-14 rsing staff to administer g capsule 1 orally once a ate."						
	During an observation on 07-17-14 at 11:00 a.m., with the Registered Nurse # 3 and Qualified Medication Aide #8 in attendance the medications were observed. The resident had three bottles of the medication.							
	indicated 30 cap	ated 05-23-14 and sules were delivered. Nurse indicated 21 ed.						
	indicated 30 cap	ated 06-20-14 and sules were delivered. Nurse indicated 14 ed.						
	contained a "Con Living," dated 1 "Medication mod include monitori prescribed times the resident.	of the resident record intract for Assisted 0-15-10 which indicated, initoring service shall ing correct medication at "which was signed by						
	A review of the	June 2014 re-write of						

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 23 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/18/2014			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6038 W 25TH ST INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	pharmacist. During interview a.m., the Qualific indicated that where she went the [medication] carranything. She's in the she's incomplete the she's incomp	on 07-18-14 at 10:30 ed Medication Aide #8 nen the pharmacist was arough the med.						
R000412	positive tuberculin treatment for disea for infection shall to skin testing. In lieu these persons should assessment for the symptoms suggestincluding, but not in hight sweats, and are present, the inimmediately with a Based on record the facility failed who had a histor positive PPD (Puramethod used tuberculosis infeating annual risk assessment for the symptoms suggestincluding, but not in high the symptoms who had a histor positive PPD (Puramethod used tuberculosis infeating annual risk assessments).	Noncompliance documented history of a skin test, adequate ase, or preventive therapy be exempt from further of a tuberculin skin test, build have an annual risk de development of tive of tuberculosis, imited to, cough, fever, weight loss. If symptoms dividual shall be evaluated	R000412	the corrective action taken is ensure all residents with a his of positive ppd have an annurisk assessment done. the facility id other residents havithe potential to be affected by audit to see if any other resh positive ppd other than the thin question already the measput into place were to have the	ng y an lad a laree sures			

State Form Event ID: 39XV11 Facility ID: 001132 If continuation sheet Page 24 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/18/2014				
			B. WING		07/16/2014			
NAME OF PROVIDER OR SUPPLIER INDEPENDENT LIVING CLUB			STREET ADDRESS, CITY, STATE, ZIP CODE 6038 W 25TH ST INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	which included a history of tubero to assess the resi and symptoms s for 3 of 3 supple residents. (Residual). Findings included 1. The record for reviewed on 07-Diagnoses included to, a positive PP admitted to the fund had a chest admission. Duri review, the last of resident was data record lacked an assessment. 2. The record for reviewed on 07-Diagnoses included on 07-Diagnoses included and assessment. The record contains admitted to the	a positive skin test, or a ulosis the facility failed dents annually for signs aggestive of tuberculosis mental sampled dents "H", "I", and "J" E: Or Resident "H" was 18-14 at 8:40 a.m. ded, but were not limited D. The resident was facility on 10-02-2009 ex-ray at the time of ng clinical record chest x-ray for this ed 01-16-2013. The annual TB risk Or Resident "I" was 18-14 at 9:30 a.m. ded, but were not limited aberculosis. The resident the facility on 07-27-11. Anned a chest x-ray dated last PPD testing was 04-06-2012 with a The resident record PD testing or an annual		medical director along with the perform the assessments on three residents in question. If other should arise in the future they will be assessed annually well as the 3 in question will continue to be annually assessed. the surveyor gave a form while she was on site if future assessment. The rn will monitor any future resident admitted with the potential for the medical director will also monitor per our meeting july 3 2014 addendum: the facility wensure the screenings are dorn by the new log book and sche implemented together by the nursing staff and office staff. A resident charts were audited the ensure each has an up to date test or cxr. If they did not, one was completed, a copy has be made of each original to test or cxr of all residents and put into the new log book the original is left in the chart itself, a month is schedule is in the log book as well to ensure future yearly compliance, the don with have a copy to complete any needed yearly to tests or cxr of the new month, any new admit added to the log book info as as the copy of the or cxr upon the tagget of the schedule are updated uponew admits or changes in resident situation, the copies and the policy of the order of the schedule are updated uponew admits or changes in resident situation, the copies and the medical director in the medical	he any e //, as us or I tb. 0, viill ne dule etb een or os y II upon t is well heir of n are y			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	, pull place 00		00	COMPLETED		
			A. BUILDING B. WING			07/18/2014		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER			6038 W 25TH ST					
INDEPENDENT LIVING CLUB								
	NDENT LIVING CLO	JB	INDIANAPOLIS, IN 46224					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE	
	3. The record for Resident "J" was			also implemented bringing a scanner for all of her med records and changes upon her visits, the				
	reviewed on 07-18-14 at 10:00 a.m.							
	Diagnoses included, but were not limited					ne		
	to, a positive PPD test dated 11-01-2012				med director will keep these copies in her office for a triple			
	and the record indicated a local medical				back up. the office manager	•		
					maintains the log book with in	fo		
	group determined the resident had				given to her in nursing report I			
	"latent" TB which was "not contagious."			the don and entire nsg staff				
	The record further indicated the resident							
	received prophylactic medication prior to							
	the admission date of 07-10-2013.							
	The record lacked further testing							
	including a chest x-ray or annual TB risk							
	assessment since the time of admission.							
	4 55 6 55111 6 11 6 5111 6	01 WW 1111051011.						
	During an interview on 07 18 14 at 10:20							
	During an interview on 07-18-14 at 10:30							
	a.m. the Qualified Medication Aide							
		licated she was unaware						
	of a form to be completed to assess the							
	resident. " I know we don't have those							
	here."							
	This State tag re	lates to Complaint						
	IN00152030.							
	11100152050.							

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